



INSTITUTE OF  
MEDICAL ULTRASOUND

**Enrollment Agreement for General Cross Training Courses**

**Contact Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile/Cell \_\_\_\_\_

Email Address \_\_\_\_\_

**Sonography Background:**

\_\_\_\_\_ **Formal Training Program**

Major \_\_\_\_\_ Year Graduated \_\_\_\_\_

Name of Program \_\_\_\_\_

Length of Program \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_ **On-the-job-training**

Major \_\_\_\_\_ Year Completed \_\_\_\_\_

Name of Clinic \_\_\_\_\_

Length \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_ **Registries/Credentials**

Abdomen \_\_\_\_\_ Obstetrics/Gynecology \_\_\_\_\_

Adult Cardiac \_\_\_\_\_ Pediatric Cardiac \_\_\_\_\_

Vascular \_\_\_\_\_ Breast \_\_\_\_\_

Other \_\_\_\_\_

**Registry Number:** \_\_\_\_\_

817 West Peachtree Street, Suite 207 at the Biltmore, Atlanta, Georgia 30308  
Phone: 404.881.1916 fax: 404.881.1897



**Hepatitis B. Status:**

Which of the following best describes the status regarding your Hepatitis B Series of injection that the health department recommends for all health care workers? Please initial the answer that fits your status.

\_\_\_\_\_ I have started or will start the Hepatitis B vaccine prior to registering for any of the Institute of Medical Ultrasound’s clinical training courses. I will notify the Institute of Medical Ultrasound upon initiation and completion of the series.

\_\_\_\_\_ I have previously received the Hepatitis B vaccine series of injections and can provide documents or titer results.

\_\_\_\_\_ I have decided **NOT** to receive the Hepatitis B vaccine even though I understand that my clinical training and future profession may expose me to blood or other infectious materials; however, by not receiving the vaccine it will seriously limit the Institute’s ability to assign me to a clinical training facility and that limiting my assignment to a clinical training facility may negatively impact my ability to graduate from the program.

**Course Selection:**

*Please designate your choices by initialing each course for which you are enrolling in the “select” column and then initialing the total cost.*

<b>General Sonography Courses</b>	<b>TYPE</b>	<b>Schedule is: (10 wks unless specified)</b>	<b>Cost</b>	<b>Select by initialing your choice</b>
<b>DMSG 230</b> Abdomen/Superficial Sonography I*	Theory	Th 4-5 p.m. ( wj1,3,5,7,9)	\$ 850	
<b>DMSG 231</b> OB/Gyn Sonography I*	Theory	Th 4-5 p.m. ( wk 2,4,6,8,10)	\$ 850	
<b>DMSG 240</b> Abdomen/Superficial Sonography I*	Theory	Th 5:30-6:30 p.m.(wk 1,3,5,7,9)	\$ 850	
<b>DMSG 241</b> Ob/Gyn Sonography I*	Theory	Th 5:30-6:30 p.m. (wk 2,4,6,8,10)	\$ 850	
<b>DMSG 250</b> Abdomen/Superficial Sonography III*	Theory	Th 7-8 p.m. (wk 1,3,5,7,9)	\$ 850	
<b>DMSG 251</b> Ob/Gyn Sonography III*	Theory	Th 7-8 p.m. (wk 2,4,6,8,10)	\$ 850	
<b>DMSG 232-252</b> General Scan Lab	Lab	By appointment	\$ 900	
<b>DMSG 123</b> General Clinic I	Clinic	100 hours	\$1000	
<b>DMSG 233</b> General Clinic II	Clinic	160 hours	\$1200	
<b>DMSG 243-253</b> General Clinic III-IV	Clinic	240 Hours	\$1800	
<b>DMSC 263</b> General Clinic V	Clinic	320 Hours	\$2000	
<b>Total Cost</b>				

**\*\*Textbook (s) may be required. \*\***



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**Selection of Term:**

\_\_\_\_\_ Fall Term: October 2, 2008 \_\_\_\_\_ Winter Term: January 8, 2008

\_\_\_\_\_ Spring Term: April 2, 2008 \_\_\_\_\_ Summer Term: July 8, 2008

**Agreement:**

*The student and Institute of Medical Ultrasound school enter into an agreement under which the student will pay tuition and other fees that may apply (example: books) as indicated above as well as adhere to Institute of Medical Ultrasound's protocol and procedures as set forth in the student catalog. Institute of Medical Ultrasound will instruct the student in the curriculum listed above in accordance with the education laws and the commissioner's regulations.*

**NOTE: This Enrollment agreement may be cancelled within 3 business days of the signature from the student. The cancellation must be in writing and signed by the purchaser, which is the student.**

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Agreement Acceptance by School Faculty:**

Enrolling School Personnel  
Printed Name & Title: \_\_\_\_\_

Enrolling School Personnel  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Executive or Program  
Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Submittal:**

Sign and submit the agreement via fax or mail; however the original is required.

Institute of Medical Ultrasound  
817 W. Peachtree St, Ste 207  
Atlanta, GA 30308, 404-881-1916-Office  
404-881-1897-Fax

You may make payment payable to Institute of Medical Ultrasound via check or money order which must accompany signed agreement or you may use our secured PayPal account found on our website: [www.imultrasound.com](http://www.imultrasound.com) under tuition and fees payment. If you have any questions or concerns, please contact the school or email Sherie Kirksey at [skirksey@imultrasound.com](mailto:skirksey@imultrasound.com)

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